MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 39

CERTIFICATE OF DEATH

06600

★ Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Alleganay

City or town: Barton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Barton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Ellen Berry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry D. Berry

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): April 20, 1871

8. AGE: Years: 74 | Months: 2 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Barton, Alleg. Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER — 12. Name: Solomon Brooks

FATHER — 13. Birthplace: Penn.

MOTHER — 14. Maiden name: Mary E. Broadwater

MOTHER — 15. Birthplace: Garrett Co. Md.

16. Informant: Harry D. Berry

Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 20 1945 (month) (day) (year)

Cemetery or crematory: Laurel Hill

Location: Mocsey, Md.

18. Funeral director: Ellsworth L. Beal

Address: Westernport, Md.

19. July 18 1945 (Date rec'd by registrar) S.A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17, 1945, at 5:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945, to July 17 1945

and that I last saw h alive on 19

Immediate cause of death	DURATION
Arterio sclerosis	
Unknown	
Due to	
Due to	
Other conditions: Chronic Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: S. A. Boucher M. D.

Address: Barton, Md. Date signed: 7/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06601

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Dans Mt. Near Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Dans Mt. Near Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Alice M. V. Bittinger

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harrison Bittinger
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): October 3, 1881

8. AGE:

Years	Months	Days	If less than one day
63	9	21	...hrs. ...min.

9. Birthplace: Farm near Swanton, Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home

FATHER
12. Name: Sam Warwick
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Mary Warwick
15. Birthplace: Swanton, Garrett Co, Md.

16. Informant: Harrison Bittinger
Address: Dan's Mountain Near Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 27, 1945 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Roscoe, Md.

18. Funeral director: D. E. Eichhorn
Address: Lonaconing Md.

19. July 26 1945 (Date rec'd by registrar) Dr. E. Donaldson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1945 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 24 1945
and that I last saw her alive on July 10 1945

Immediate cause of death: Cerebral Hemorrhage — DURATION: 2 mo.
Due to: [redacted]
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: H. E. Gatling M.D.
M. D. or other
Address: Frostburg Md. Date signed: 7/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

06602

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred: 223 So. Smallwood St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 223 So. Smallwood St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret Armentrout Bowers

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife William H. Bowers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 16- 1865

8. AGE:

Years	Months	Days	If less than one day
79	8 7	29	..... hrs. ..... min.

9. Birthplace Pendleton County Wva (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Jesse Clark Armentrout

13. Birthplace West Virginia

MOTHER 14. Maiden name Sarah Jane Kile

15. Birthplace West Virginia

16. Informant Mrs. Nellie Litz

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18, 1945 (month) (day) (year)

Cemetery or crematory Kile Cemetery

Location Pendleton Co., W. Va.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. July 16 1945 (Date rec'd by registrar) Winter R. Prantz, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945 to July 15 1945 and that I last saw her alive on July 15 1945

Immediate cause of death	DURATION
Chronic myocarditis	1 yrs
Due to	
Due to	
Other conditions Arteriosclerosis	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. T. Trevaskis M.D. M. D. or other

Address Cumberland, Md Date signed July 15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06603

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Frostburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Allegany
City or town Midland, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war World War I

3. (a) FULL NAME Thomas Earl Brinegar

3. (b) Social Security Number 211-09-4932

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Catherine Hammersmith 6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) April 23, 1894

8. AGE:

Years	Months	Days	If less than one day
51	3	5	hrs. min.

9. Birthplace Parkersburg, W. Va. (Town, county, and state)
10. Usual occupation Steel Worker
11. Industry or business Baltimore Steel Mill

FATHER
12. Name Hugh Brinegar
13. Birthplace West Virginia

MOTHER
14. Maiden name Clarinda Right
15. Birthplace West Virginia

18. Informant Mrs. Flora E. Brinegar
Address Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 1945 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg, Md.
18. Funeral director M. Eichhorn
Address Lonaconing, Md.

19. 7-31 1945 (Date rec'd by registrar) Mrs. Hawley M. Rose Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28th 1945, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1945, to July 28 1945 and that I last saw him alive on July 28 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis.	3
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. E. Gatten M.D. M. D. or other
Address Frostburg, Md. Date signed 7/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

06604

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 Race St
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Rose Catherine Brinker

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George A Brinker

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 24, 1877

8. AGE:

Years	Months	Days	If less than one day
67	8	17	____ hrs. ____ min.

9. Birthplace: Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home.

FATHER
12. Name: Patrick King
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Tierney
15. Birthplace: Ireland

16. Informant: George A Brinker
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 14 '45 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. July 13 1945 (Date rec'd by registrar) Winter R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11, 1945 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 45 to July 11, 1945

and that I last saw her alive on July 11, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to: Occlusion L. Femoral Artery	24 hrs
Due to: Hypertension	3 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Wm. L. Lucas M.D.
M. D. or other

Address: Cumberland Date signed: July 11, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-H)

CERTIFICATE OF DEATH

06605

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
418 Goethe St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 418 Goethe St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mae F. Brunk

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Welby Leon Brunk

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 12, 1891

8. AGE: Years	Months	Days	If less than one day
54	0	0	....hrs. ....min.

9. Birthplace Reeces Mill, W.Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Samuel S. Flanagan

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Etta Taylor

MOTHER 15. Birthplace Richie Co. Virginia

16. Informant Welby L. Brunk

Address 418 Goethe St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-15-45 (month) (day) (year)

Cemetery or crematory Queenspoint Cemetery

Location Keyser, W.Va.

18. Funeral director N.L.Rogers Funeral Directors

Address Keyser, W.Va.

19. July 15 1945 (Date rec'd by registrar) Winter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12th., 1945 about 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h ....alive on ....19....

Immediate cause of death	DURATION
Asphyxiation by illuminating gas.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 7-12-45

Where did injury occur? Cumberland, Allegany, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) her home

Means of injury illuminating gas Injured at work? no

23. SIGNATURE Burris H. Brown, M.D.
M. D. or other

Address Cumberland, Maryland Date signed 7-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-d)

C6606

CERTIFICATE OF DEATH ★

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany — Frostburg

City or town: Mt. Savage, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 5 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Thomas Mc Burnell

3.(b) Social Security Number: 216-22-6438

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Leslie Burnell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 28th, 1900

8. AGE: Years: 45 | Months: 0 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Mt. Savage, Allegany, Md. (Town, county, and state)

10. Usual occupation: Surface Work

11. Industry or business: Cyclamine Corp.

FATHER — 12. Name: Thomas R. Hall

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Alice Waltzman

MOTHER — 15. Birthplace: Pa.

18. Informant: Mrs. Chas. Burns

Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 16-1945 (month) (day) (year)

Cemetery or crematory: Episcopalian Cemetery

Location: Mt. Savage, Md.

18. Funeral director: Jacob Dafler

Address: Frostburg, Md.

19. 7-14 1945 Mrs. Dailey H Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1945, at 6a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1945 to July 13 1945 and that I last saw him alive on July 12 1945

	DURATION
Immediate cause of death: Embolism	
Due to: Appendectomy	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: F. Allan G. Hunnicutt M. D. or other

Address: Cumberland Md. Date signed July 14 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12-L)

CERTIFICATE OF DEATH

06607

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. VA. County: MINERAL
City or town: LAUREL DALE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: EMMA LOTTIE BURGESS

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? ? 1902

8. AGE: Years	Months	Days	If less than one day
43	?	?	hrs. min.

9. Birthplace: MAYSVILLE, W. VA.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: GEORGE BURGESS
13. Birthplace: W. VA.

MOTHER
14. Maiden name: SARA JANE MACKLEY
15. Birthplace: MARYLAND

16. Informant: George Burgess
Address: Laurel Dale, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 13 45 (month) (day) (year)
Cemetery or crematory: Burgess Family
Location: Laurel Dale, W. Va.

18. Funeral director: N. S. Rogers Funeral Directors
Address: Keyser, W. Va.

19. 7-11-45 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 11, 1945, 19..., at 10: A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 19 45 to July 11 19 45 and that I last saw h[illegible] alive on July 11 19 45

Immediate cause of death	DURATION
Intestinal obstruction	
Due to: Mesenteric thrombosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Gangrenous small gut

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. G. Grace M. D. or other
Address: Cumberland Md. Date signed: July 11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93rd

06608

CERTIFICATE OF DEATH ★

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 82yrs
Hospital, institution, or street address where death occurred:
40 Browning St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give neerest town)
Street No. 40 Browning St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Louise Clark

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Joseph H. Clark
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 8. 1863

8. AGE: Years	Months	Days	If less than one day
82	2	7	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany, Md. (Town, county, and State)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John M. Trieber
13. Birthplace Germany

MOTHER
14. Maiden name Emma Wright
15. Birthplace Germany

16. Informant Sylvester J. Clark
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9 1945 (month) (day) (year)
Cemetery or crematory Philo's Cem.
Location Westernport Md.
18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.

19. July 9 1945 Hunter R Dent M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1944 to July 7 1945 and that I last saw h[illegible] alive on July 6 1945

Immediate cause of death	DURATION
Coronary Thrombosis	24 hrs.
Hypostatic Pneumonia	10 days
Due to Senility and Arteriosclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clay K. Jones M.D. or other
Address Cumberland Date signed 7/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 yrs

Hospital, institution, or street address where death occurred:
Allegany Hospital-Decatur Street

How long in hospital or institution? 65 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 210 Milton Street
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War

3. (a) FULL NAME: James N. Conner

3. (b) Social Security Number: 215-05-7112

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Hazel Twigg

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 22 1897

8. AGE: Years	Months	Days	If less than one day
48	5	—	..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business

FATHER — 12. Name: Harvey W. Conner

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Margaret Prusaman

MOTHER — 15. Birthplace: Md.

16. Informant: Mrs Ruth Delauare

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25 45 (month) (day) (year)

Cemetery or crematory: Geo Beneficial Cem

Location: Cumberland

18. Funeral director: Louis Stein Jane

Address: Cumberland

19. July 25 1945 Nate Ex Dent Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22, 1945, at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 15 1945 to July 22 1945 and that I last saw h.. alive on July 22 1945

Immediate cause of death	DURATION
Chronic myocarditis	6 Mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causee, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. W. Trenskey, M.D.
M. D. or Other

Address: Cumberland Md Date signed July 23-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

CERTIFICATE OF DEATH

06610

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEG.
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No.: CRESAP DRIVE, RT #5
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MR. ALAN F. COULEHAN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: RUTH E. STALLINGS
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): SEPT. 15, 1882

8. AGE: Years	Months	Days	If less than one day
62	9	19	....hrs. ....min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: NONE
11. Industry or business:

FATHER
12. Name: JOHN F. COULEHAN
13. Birthplace: MD.

MOTHER
14. Maiden name: NINA DILLEY
15. Birthplace: MD.

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7, 1945 (month) (day) (year)
Cemetery or crematory: Rosehill Cem.
Location: Cumberland, Md.
18. Funeral director: Louis Stein Inc
Address: Cumberland Md.
19. July 6, 45 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 4, 1945, at 2:35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1945 to July 4 1945 and that I last saw him alive on July 2 July 4 1945

	DURATION
Immediate cause of death: Chronic Nephritis c	? yrs.
Edema,	?
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W P Hodges M. D. or other
Address: Cumberland, Md Date signed 7/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ag is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

06611

CERTIFICATE OF DEATH

★ Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76 yrs 2 mos. 21 days
Hospital, Institution, or street address where death occurred: Gunsdale Street
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Gunsdale Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Margaret Dunn K. Crosser

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Crosser
6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): April 17, 1869

8. AGE: Years	Months	Days	If less than one day
76	2	21	...hrs. ...min.

9. Birthplace: Lonaconing, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
FATHER 12. Name: Robert Robertson
FATHER 13. Birthplace: Scotland
MOTHER 14. Maiden name: Isabel Mason
MOTHER 15. Birthplace: Scotland
16. Informant: Mrs. Elizabeth Galbie
Address: Pittston, Penna.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. July 9 1945 (Date rec'd by registrar) W. E. Donaldson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1945, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1945, to July 8 1945 and that I last saw h-er alive on July 7 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: July 9 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

Evidence for change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

06612

CERTIFICATE OF DEATH

FILE No. G 97 JUL 25 1945

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital Cumberland Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 609 Frederick Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Davidson, Mrs. Sarah

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles Davidson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8-9-1873 1872

8. AGE: Years	Months	Days	If less than one day
72	10	3	..... hrs. ..... min.

9. Birthplace: Adams County Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Levi Fisher

13. Birthplace: Pa

MOTHER — 14. Maiden name: Eliza Brashears

15. Birthplace: Pa

16. Informant: Charles G Davidson

Address: 609 Given St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 5 1945 (month) (day) (year)

Cemetery or crematory: Davis Memorial

Location: Uhl Highway

18. Funeral director: Davis Stein Inc

Address: Cumberland Md

19. July 5 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/2 19 45 at 3:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13 19 42 to July 2 19 45

and that I last saw h.e.r alive on July 1 19 45

	DURATION
Immediate cause of death: Chronic myocarditis	2 Yrs
Due to: exhaustion	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C Bruce MD (M. D. or other)

Address: Lonaconing Md Date signed: 7-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

06613

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: 9 Great St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9 Grant
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles S. Dillon

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: May Dillon
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Mar 30 – 1879

8. AGE: Years	Months	Days	If less than one day
66	3	7	hrs. min.

9. Birthplace: Butler, Pa.
(Town, county, and state)
10. Usual occupation: Beer distributor
11. Industry or business: Cumberland Brewery
MOTHER 12. Name: Thomas Dillon
13. Birthplace: Frostburg, Md.
MOTHER 14. Maiden name: Dora Kaepel
15. Birthplace: Cumberland, Md
16. Informant: Fred Dillon
Address: Frostburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 10 – 45 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg Md
18. Funeral director: J. J. Durst
Address: Frostburg Md.
19. 7-10 1945 Mrs. Lawley N. Rice
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1945, at 11:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1945, to July 7 1945 and that I last saw h alive on July 7 1945

Immediate cause of death: Coronary Thrombosis — DURATION: 4 Days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. M. Jones M.D.
M. D. or other
Address: Frostburg Md Date signed: July 9 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
JUL 12
BUREAU V.S.

Dr. Enfield

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★

06614

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or Institution? 39 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Hampshire

City or town Levels

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Mr. Nelson G. Durst

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 12, 1881

8. AGE: Years	Months	Days	If less than one day
63	7	27	..... hrs. ..... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Farmer & Mechanic

11. Industry or business

FATHER 12. Name Jonathan T. Durst

13. Birthplace West Virginia

MOTHER 14. Maiden name Catherine Raese

15. Birthplace Maryland

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 11, 1945 (month) (day) (year)

Cemetery or crematory Ends U.V.A.

Location Ends W.Va.

18. Funeral director Mc Kee

Address Augusta W.Va.

19. July 11, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1945, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-31-, 1945, to July 9, 1945, and that I last saw h.. alive on July 9, 1945

Immediate cause of death	DURATION
Due to Nephritis	39 days.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 7-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93-a

U6615

Reg. Dist. No. 9

M

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 17 N. Great St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 N Grant

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Charles Edmunds

3.(b) Social Security Number 217-106-298

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Annie E. Edmunds

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Oct 24 - 1876

8. AGE: Years	Months	Days	If less than one day
68	9	4	hrs. min.

9. Birthplace: Bussey Pond, S. Wales (Town, county, and state)

10. Usual occupation: Refrigeration engineer

11. Industry or business

FATHER 12. Name: Joseph E. Edmunds

FATHER 13. Birthplace: Wales

MOTHER 14. Maiden name: Mary Ann Charles

MOTHER 15. Birthplace: Wales

16. Informant: Louis E. Edmunds

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31-1945 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: J. B. Dent

Address: Frostburg, Md.

19. 7-30-1945 Mrs. Nancy N. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1945, at 7:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1945 to July 28 1945

and that I last saw h... alive on July 28 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? X (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other

Address: Frostburg, Md. Date signed: 7/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06616

Reg. Dist. No. 6

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 59 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 203 Vine St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lewis Engle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

8.(b) Name of husband or wife: Susan F. Engle
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 20, 1859

8. AGE: Years	Months	Days	If less than one day
86	3	10	..... hrs. ..... min.

9. Birthplace: Somerset Co. Penna (Town, county, and state)
10. Usual occupation: Retired Dentist
11. Industry or business

FATHER
12. Name: Solomon Engle
13. Birthplace: Penna.

MOTHER
14. Maiden name: Christina Keim
15. Birthplace: Penna

16. Informant: Dr. Lewis F. Engle
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6 1945 (month) (day) (year)
Cemetery or crematory: Mausoleum. Rose Hill Cem
Location: Cumberland Md.

18. Funeral director: W. H. Fredlock, Jr.
Address: Piedmont, W. Va.

19. July 6 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 19 45, at 11.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 45, to July 3, 19 45 and that I last saw h[im] alive on July 3 19 45

Immediate cause of death	DURATION
Arterio-Sclerosis	
Chronic Nephritis	6 mos
Due to Chr. Myocarditis	"
Due to	
Other conditions Bronchial pneumonia (Terminal)	1 day
Chronic uremia	1 mo

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Norman Reeves, M.D. M. D. or other
Address: Westernport Md Date signed 7-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

06617

Reg. Dist. No. 7

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

1. PLACE OF DEATH

County Allegany

City or town Maskaut

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Moscow

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Fairgrieve

3.(b) Social Security Number 212-10-7895

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma Lee Fairgrieve 6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1883

8. AGE: Years	Months	Days	If less than one day
62	6	1	hrs. min.

9. Birthplace Baston, Alleg Md. (Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal mine

FATHER 12. Name James Fairgrieve

FATHER 13. Birthplace Scotland

MOTHER 14. Maiden name Amanda Yarnick

MOTHER 15. Birthplace Baston, Md.

16. Informant Mrs. William Fairgrieve

Address Moscow, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 1, 1945 (month) (day) (year)

Cemetery or crematory Laurel Hill

Location Moscow, Md.

18. Funeral director Mrs. Fay Coal Berry

Address Westernport, Md.

19. July 31 1945 S.A. Boucher (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1940, to July 1945

and that I last saw h. alive on July 27 1945

Immediate cause of death Myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P.E. Berry M. D. M. D. or other

Address Piedmont W Va Date signed 8-6-45

WITHIN CORPORATE LIMITS

DR. WILLIAMS
Sent to Duncan's
Thomas W.Va.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

06618

★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: WEST VIRGINIA County: TUCKER
City or town: THOMAS
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME
MR. GROVER C. FANSLER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: CLARA SATERFIELD
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): FEB 26, 1885

8. AGE: Years	Months	Days	If less than one day
60	4	24	hrs. min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)
10. Usual occupation: BARBER
11. Industry or business

FATHER
12. Name: ANDREW FANSLER
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden name: MARTHA REEB
15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem
Location: Thomas W. Va
18. Funeral director: Duncan Funeral Home
Address: Thomas, W. Va.

19. July 21, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 20 1945 12:57A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1945 to July 20 1945 and that I last saw him alive on July 20, 1945

Immediate cause of death	DURATION
Status Asthmaticus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed 7-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. ELIASON

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

CERTIFICATE OF DEATH ★

06619

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 501 EASTERN AVE., C.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MICHAEL JOSEPH FARRELL

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUGUST 17, [illegible] 1941

8. AGE: Years	Months	Days	If less than one day
3	10	25	..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name CHARLES J. FARRELL
13. Birthplace MARYLAND

MOTHER 14. Maiden name LILLIAN ISOM
15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14, 1945 (month) (day) (year)
Cemetery or crematory ST. Patricks
Location Cumberland, Md.

18. Funeral director Charles L. George
Address Cumberland, Md.

19. July 14 1945 Walter R. Krantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 12, 45 1:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 10, 1945 to JULY 12, 1945 and that I last saw him alive on JULY 12, 1945

Immediate cause of death	DURATION
(a) Acute Nephritis	4 days
Due to: (b) Virus Infection	6 days
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Negative

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE H. C. Eliason M.D.
Address 136 Vannort Ave Cumberland Md. M.D. or other
Date signed 7/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06620

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 3 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: GARRETT
City or town: FRIENDSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: CHARLES R. FIKE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: BERTHA COFFMAN
6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): SEPT. 20 1911

8. AGE: Years	Months	Days	If less than one day
33	9	13	hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: TRUCK DRIVER
11. Industry or business

FATHER
12. Name: CHARLES FIKE
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: BERTHA RILEY
15. Birthplace: MARYLAND

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial, cremation, or removal. Which? Burial Date thereof July 5-1945 (month) (day) (year)
Cemetery or crematory: Selbysport Md
Location: Garrett County

18. Funeral director: H.T. Rodaheaver
Address: Markleysburg Pa

19. July 5 1945 (Date rec'd by registrar) Vinton R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 3 45 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 19 45 to July 3 19 45
and that I last saw h[illegible] alive on July 3 19 45

Immediate cause of death: Cerebral Embolism — DURATION: less than 24 hrs.
Due to: Laryngeal Angina Edema
Due to: Scarlet Fever
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.: None
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. F. Williams M. D.
Address: Cumberland Date signed: 7-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

(M)

MARGIN RESERVED FOR BINDING

(1)

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

06621

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State W. Va. County Grant

City or town Fort Ashby (If outside city or town limits, write RURAL and give nearest town)

Street No. — Round Bottom (If rural, give LOCATION)

2.(a) If veteran, name war — ✓

3.(a) FULL NAME William Zane Flora, Jr.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 27 1942

8. AGE: Years	Months	Days	If less than one day
3	6	8	..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Wm Z Flora

13. Birthplace W. Va.

MOTHER 14. Maiden name Mildred Portmus

15. Birthplace Md.

16. Informant Wm Z Flora Sr.

Address Ft Ashby

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 2 45 (month) (day) (year)

Cemetery or crematory Ft Ashby Cem

Location Ft Ashby W. Va

18. Funeral director Louis Stein Inc

Address Cumberland.

19. Aug. 1 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30th 1945 at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
General Peritonitis	24 hrs.
Due to Ruptured appendix	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. .....

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Pierce H. Dorsey M.D.

Address Cumberland, Maryland M. D. or other

Date signed 7-30-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-5)

CERTIFICATE OF DEATH

06622

★ Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred: Allegany Hospital Cumberland Md.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 311 Selby Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Frost - Bernadette B.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Meshach S. Frost
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 18, 1880

8. AGE: Years	Months	Days	If less than one day
64	7	29	..... hrs. ..... min.

9. Birthplace: Frostburg (Town, county, and state) Md.
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Peter Cordial
13. Birthplace: Va
MOTHER 14. Maiden name: Katherine Kisby
15. Birthplace: Frostburg Md
16. Informant: Meshach Frost
Address: Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20 45 (month) (day) (year)
Cemetery or crematory: St. Peter & Pauls (Luth)
Location: Cumberland
18. Funeral director: Louis Stein, Inc
Address: Cumberland
19. July 20, 19 45 (Date rec'd by registrar) Winter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 19 45 at 12:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-15-45 19 to 7-17-45 19 and that I last saw h.. alive on 7-17-45 19

Immediate cause of death	DURATION
Intestinal Obstruction	
Due to: Post. Operative Adhesions	4 days
Due to	
Other conditions: Toxemia	4 days.

(Include pregnancy within 3 months of death)

Major findings of operation: Complete Obstruction
Problem due to adhesions Date of op. 7-16-45
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Cumberland Md Date signed 7-17-45

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH ★

06623

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Several years

Hospital, Institution, or street address where death occurred: 710 Yale St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 710 Yale St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Emma P. Gadbois

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Joseph G. Gadbois

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 9 1879

8. AGE: Years	Months	Days	If less than one day
66	0	0	....hrs. ....min.

9. Birthplace Canada (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name — Perrin

FATHER 13. Birthplace Canada

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace "

16. Informant Mrs Francis Clay

Address 710 Yale St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12 1945 (month) (day) (year)

Cemetery or crematory St. Mary's Burial Park

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md

19. July 11, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1945 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h.....alive on .....19....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to (Pneumonia) Dead	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. R. Lemmon M. D. or other

Address Cumberland Date signed July 10, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

Evidence for change of age is shown on FILM G96 JUL 19 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH ★

06624

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80. Years
Hospital, institution, or street address where death occurred:
505. Greene St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 505. Greene St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward Gates

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: Maude Gates
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 20, 1855

8. AGE: Years	Months	Days	If less than one day
~~89~~ 89	6	19	..... hrs. ..... min.

9. Birthplace: Cresaptown, Allegany Co, Maryland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farming

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Edward Gates, Jr
Address: 505. Greene St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/12/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. July 18, 1945 Walter F. Frantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1945 at 4-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to July 9 1945 and that I last saw h... alive on July 9 1945

Immediate cause of death	DURATION
Chronic Myocarditis	3 months
Due to Hypertension Heart	2 y
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: C. Allen G. Hamm M.D.
M.D. or other
Address: ..... Date signed July 10 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

06636

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All his life

Hospital, institution, or street address where death occurred:

Miner's Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Borden Mine

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Hager (Hager)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Taylor

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22 1864

8. AGE: Years: 77 | Months: 0 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Borden, Allegany, Md. (Town, county, and state)

10. Usual occupation: Retired Coal Miner

11. Industry or business

FATHER — 12. Name: John Hager

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Cristine Coppenrath

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs. Edward Elliott

Address: Eckhart Mines, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Kaler

Address: Frostburg, Md.

19. 7-30 1945 (Date rec'd by registrar) Mrs. Harvey H. Rose Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945, at 5:30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 22 1945 to July 27 1945

and that I last saw him alive on July 26 1945

Immediate cause of death	DURATION
Fracture neck of femur	5 days
Diabetes Mellitus	?
Due to	
Due to Accidental fall.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: W. Gallen M.D. M. D. or other

Address: Frostburg, Md. Date signed: 7/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

Dr. Eliason

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

CERTIFICATE OF DEATH

06625

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Dawson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Russell Lee Hise

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 14, 1945

8. AGE: Years | Months | Days: 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Dawson, Maryland (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: Adam Hise

FATHER — 13. Birthplace: Burlington, West Virginia

MOTHER — 14. Maiden name: Mary Virginia Shaffer

MOTHER — 15. Birthplace: Maryland

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 29 1945 (month) (day) (year)

Cemetery or crematory: Dawson

Location: Rawlings, Md.

18. Funeral director: Ellsworth & Bond

Address: Westernport Md

19. July 29 1945 (Date rec'd by registrar) Winter K. Wantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28, 1945, at 7:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1945, to July 28 1945

and that I last saw h... alive on July 27 1945

	DURATION
Immediate cause of death: Malnutrition	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: A. L. Eliason M.D. M. D. or other

Address: 76 Prospect St Cumberland Md Date signed: 7/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

✓ WITHIN CORPORATE LIMITS

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (466)

06626

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 yrs.
Hospital, institution, or street address where death occurred:
217 Washington, St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 217 Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alice May Holzshu
3.(b) Social Security Number None

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced MARRIED
6.(b) Name of husband or wife Chas. G. Holzshu
6.(c) If alive, give age ___ years
7. Birth date of deceased (mo., day, yr.) MAR 10, 1875
8. AGE: Years 70 Months 3 Days 25 If less than one day ___ hrs. ___ min.
9. Birthplace Fredrick Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER
12. Name David M. Zieler
13. Birthplace Maryland
MOTHER
14. Maiden name ?
15. Birthplace
16. Informant Chas. G. Holzshu
Address Cumberland, Md
17. Burial
(Burial, cremation, or removal, Which?)
Date thereof July 7, 1945
(month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland, Md.
18. Funeral director Louis Stein Inc
Address Cumberland, Md.
19. July 6, 1945 Winter R. Frantz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1945, at 12 45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1945, to July 5 1945
and that I last saw her alive on July 4 1945

	DURATION
Immediate cause of death Carcinomatosis of abdomen	4 mos
Due to Carcinoma of stomach	8 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. W. Chase M.D. M. D. or other
Address 26 Unions St Cumberland Md Date signed 7/5/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06627

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany County
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 521 Henderson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Hughes

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	widower

6.(b) Name of husband or wife: Bertha May Hughes
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 21 1876

8. AGE: Years	Months	Days	If less than one day
75	5	10	..... hrs. ..... min.

9. Birthplace: Mt Savage Allegany Co Md
(Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: School

FATHER
12. Name: Edward Hughes
13. Birthplace: Mt Savage Md

MOTHER
14. Maiden name: Hannah Baxter
15. Birthplace: Unknown

16. Informant: Mrs Sarah Minnick
Address: Rt 3. Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/3/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland Md

18. Funeral director: William H. Light
Address: Cumberland Md

19. Aug 1, 1945 (Date rec'd by registrar) Winter R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17, 1945 to July 31, 1945 and that I last saw h... alive on July 31, 1945

Immediate cause of death	DURATION
Influenza-pneumonia	7 wks
Due to: Fatty Liver of Pregnancy	
Due to:	
Due to:	
Other conditions:	

(Includo pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: Man in R with smallpox R Hosp
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of June 5 '45
Where did injury occur? Cumberland Allegany Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) School House where he was janitor
Means of injury Fell on steps Injured at work? yes

23. SIGNATURE: H. Alex G. Mason M.D.
M. D. or other
Address: Cumberland Date signed: July 31 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-n)

CERTIFICATE OF DEATH

06628

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Gilmore (near Lonaconing)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Unknown
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Gilmore (near Lonaconing)
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Thomas A. James

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Ella Hay Stewart
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): October 9, 1867

8. AGE:

Years	Months	Days	If less than one day
77	8	19	...hrs. ...min.

9. Birthplace: England (Town, county, and state)
10. Usual occupation: Coal Mining
11. Industry or business: Consolidation Coal Co.
FATHER — 12. Name: Thomas James
FATHER — 13. Birthplace: England
MOTHER — 14. Maiden name: Unknown
MOTHER — 15. Birthplace: Unknown
16. Informant: Raymond James
Address: Gilmore
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 31, 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing Md
19. July 31 1945 (Date rec'd by registrar) D. E. Bowman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28, 1945 at 12:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 19 45 to — 19 —
and that I last saw him alive on July 28 - 45 19 —

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury — Injured at work?

23. SIGNATURE: R. Berry M. D. or other M.D.
Address: Piedmont, W. Va. Date signed 7/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (145-G)

06629

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margret Ethel Karalewicz

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife John Karalewicz

6.(c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) August 14, 1918

8. AGE:

Years	Months	Days	If less than one day
26	11	5	...hrs. ...min.

9. Birthplace Mt Savage-Alleg-Md.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name Michael Lynch
13. Birthplace Mt. Savage Md.

MOTHER
14. Maiden name Mary Beafaith
15. Birthplace Mt. Savage Md.

16. Informant Michael Lynch
Address Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23-45 (month) (day) (year)

Cemetery or crematory St. Patricks

Location Mt Savage Md.

18. Funeral director J. J. Durst

Address Frostburg Md.

19. 7-21-45 Mrs. Maudy N. Rae
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945, at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 1945, to July 19, 1945, and that I last saw h... alive on July 19, 1945.

	DURATION
Immediate cause of death Pulmonary embolism	10 min
Due to Infected abortion	3 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Infected retained placental tissue Date of op. 7/19/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda Laurel Kelly M.D.
M. D. or other

Address Frostburg Date signed 7/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

★ 06630 Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
217 Carroll St, Cumberland, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 217 Carroll St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Beda C. Lilya

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Frank H. Lilya
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 29. 1866

8. AGE: Years	Months	Days	If less than one day
78	6	14	hrs. min.

9. Birthplace: Sweden (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John Eck
13. Birthplace: Sweden

MOTHER
14. Maiden name: Anna Wilson
15. Birthplace: Sweden

16. Informant: Miss Ellen Lilya
Address: 217 Carroll St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 15 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md

19. July 15 1945 (Date rec'd by registrar) Minter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13th 1945, at 1030? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1945, to July 13 1945 and that I last saw h[illegible] alive on July 13 1945

Immediate cause of death: Diabetes Mellitus — DURATION
Due to: and
Due to: Uremia
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. F. Mackesey M.D. M.D. or other
Address: 49 Greene st Date signed: 7-14-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06631

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Minutes

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 10 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Morgan

City or town: Magnolia
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

John Manning

3.(b) Social Security Number

236-01-9212

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Missouria Manning

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): January 30 1891

8. AGE: Years	Months	Days	If less than one day
54	5	13	...hrs. ...min.

9. Birthplace: Kifer, Morgan Co, West Virginia
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business: Western Maryland Railroad

FATHER
12. Name: James P. Manning
13. Birthplace: Sleepy Creek, Md

MOTHER
14. Maiden name: Mary Bryan
15. Birthplace: Mill Stone, Md.

16. Informant: James H. Manning

Address: 329, Williams St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/45 (month) (day) (year)

Cemetery or crematory: Horn Cemetery

Location: Magnolia, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 16, 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13th., 1945 at about A. 11:15 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Prince H. Brown M.D.
M. D. or other

Address: Cumberland, Maryland Date signed 7-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

06632

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, institution, or street address where death occurred:
316 Broadway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 316 Broadway
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Alta Marie Marks.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Wm F. Marks.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 19 1881

8. AGE: Years	Months	Days	If less than one day
63	9	2	..... hrs. ..... min.

9. Birthplace Irwin Westmoreland Co, Pa
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER 12. Name Samuel Teasley

13. Birthplace Greensburg, Pa.

MOTHER 14. Maiden name Lenisa Smith

15. Birthplace South Bend, Pa.

16. Informant William H. Marks

Address 316 Broadway

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 24 1945 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md,

18. Funeral director John J Hafer

Address Cumberland Md.

19. July 24 1945 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945 at 1:30 P. M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ 19 ~~to~~ 19

I did not attend her death on July 24 1945

and that I last saw h... alive on 19

Immediate cause of death	DURATION
Angina Pectoris	Sudden
Due to Organic Heart Disease	7 yrs
Due to Chronic Nephritis	7 yrs
Other conditions Overweight.	

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NO Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Thos A. Swann M. D. or other

Address Cumberland Md Date signed July 25 1945

WITHIN CORPORATE LIMITS

Mr. Allison

Carl Reinoehl

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-0)

CERTIFICATE OF DEATH

06633

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route #3, Valley Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Dollie McCoy

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John I. McCoy

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): December 19 1875

8. AGE: Years	Months	Days	If less than one day
69	7	2	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joshua Toothman

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Elizabeth Kuhn

15. Birthplace: zW. Va.

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20 1945 (month) (day) (year)

Cemetery or crematory: Fairview Cem.

Location: Fairview, W. Va.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. July 20, 1945 (Date rec'd by registrar) Winter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17, 1945 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9, 1945, to July 17, 1945 and that I last saw h alive on 19

Immediate cause of death	DURATION
Cardio pulmonary renal disease	6 mos.
Due to	
Due to	
Other conditions: Ventral incisional hernia (Include pregnancy within 3 months of death)	14 yrs.

Major findings of operations: Ventral incisional hernia Date of op. 7-10-45

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. R. Irons M.D. M. D. or other

Address: Medical Bldg Date signed 7-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Outside of City Limits

Louis Bringo

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06634

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred: Park Heights - Rt. 4, Cumberland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Western part

(If outside city or town limits, write RURAL and give nearest town)

Street No. 98 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Bernadette "Kelly" Miller

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Thomas H. Miller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 1, 1880

8. AGE:	Years	Months	Days	If less than one day
	65	4	24	..... hrs. ..... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER

12. Name Francis Kelly

13. Birthplace Ireland

MOTHER

14. Maiden name Sarah Fern

15. Birthplace Ireland

16. Informant Mrs. Earl W. Coon

Address R.F.D. 4, Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28, 1945 (month) (day) (year)

Cemetery or crematory St. Patrick's Cemetery

Location Mt. Savage, Md.

18. Funeral director John J. Horan

Address Cumberland, Md.

19. July 27, 1945 (Date rec'd by registrar) Winter R. Beantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945 at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2nd 1945, to July 25 1945

and that I last saw h.. alive on July 23 1945

	DURATION
Immediate cause of death Apoplectic Stroke	6 days
Due to Chronic Hypertension	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. Bringo M.D. M. D. or other

Address Long Meadow Date signed 7-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

✓ WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-6)

CERTIFICATE OF DEATH

06635

★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 69 yrs.
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 14 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 519 MARYLAND AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war ———

3.(a) FULL NAME WILLIAM W. MORRIS

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife JULIA RYAN MORRIS
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 6 1876

8. AGE: Years	Months	Days	If less than one day
69	4	10	..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)
10. Usual occupation Tax house man
11. Industry or business City of Cumberland
12. Name of FATHER THOMAS MORRIS
13. Birthplace of FATHER ENGLAND
14. Maiden name of MOTHER LOUISE PHILLIPS
15. Birthplace of MOTHER ENGLAND
16. Informant Julia R. Morris
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jul. 19 '45 (month) (day) (year)
Cemetery or crematory Hillcrest Bur. Park
Location Cumberland, Md.
19. Funeral director Louis Stein Inc.
Address Cumberland, Md.
19. July 18 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 16, 1945, at 9:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-2 1945, to 7-16 1945 and that I last saw h. alive on 7-16 1945

Immediate cause of death	DURATION
Cirrhosis of Liver —	6 mo?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Cirrhosis of Liver — Fluid Ascites. Date of op. 7-6-45
Autopsy results ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D. B. Stone M.D.
M. D. or other
Address Medical Bldg Date signed 7-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06637

Reg. Dist. No. 8

1. PLACE OF DEATH:
County Allegany
City or town Lonaconing (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 53 yrs. 2 mo. 22 das
Hospital, institution, or street address where death occurred: Dudley Street
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newboro infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing (If outside city or town limits, write RURAL and give nearest town)
Street No. Dudley St. (If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Alvin Cecil Neat, Sr

3.(b) Social Security Number 166-09-4194

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Jessie Steele Neat
6.(c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr.) April 20, 1892

8. AGE: Years	Months	Days	If less than one day
53	2	22	hrs. min.

9. Birthplace Lonaconing Allegany Co., Md. (Town, county, and state)
10. Usual occupation Coal Mining
11. Industry or business Big Vein Coal Co. of Lonaconing
FATHER 12. Name Joseph Neat
13. Birthplace Staffordshire, England
MOTHER 14. Maiden name Edna Jane Pritchard
15. Birthplace Allegany - Near Frostburg, Md.
16. Informant Mrs. Edna Schlerth
Address Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15, 1945 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg, Md.
18. Funeral director Wm. Eichhorn
Address Lonaconing, Md.
19. July 13 1945 Dr. Thomas Lyon
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1945 at 12:55 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/14 1944 to 7/12 1945
and that I last saw him alive on 7/10 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to Uremia	2 wks
Due to Cardiovascular Renal Disease	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Hilda Furbee Utley M.D.
M. D. or other
Address Frostburg, Md. Date signed 7/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

06638

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 615 Piedmont Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Henry Often

3. (b) Social Security Number 214-05-4809

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Grace Jenkins

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec 29, 1904

8. AGE: Years 40 Months 7 Days 1 If less than one day ... hrs. ... min.

9. Birthplace: Eckhart Mines, Allegany Co, Md (Town, county, and state)

10. Usual occupation: Steward

11. Industry or business: Merchant Marine

FATHER 12. Name: Patrick Often

13. Birthplace: Germany

MOTHER 14. Maiden name: Anna Kreitzburg

15. Birthplace: Eckhart Mines Md.

16. Informant: Mrs Paul Weller

Address: 615 Piedmont Ave - Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 1, 1945 (month) (day) (year)

Cemetery or crematory: Evangelical Zion Cemetery

Location: Frostburg Md

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. July 31 1945 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30th., 1945, at 3:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Shock; Hemorrhage (fract. Pelvis and other injuries)	14 hrs. 25 min.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 7-29-45

Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) railroad

Means of injury: fall from moving cars. Injured at work? no

23. SIGNATURE Bruce H. Brown, M.D. M. D. or other

Address: Cumberland, Maryland Date signed 7-30-45

Deputy Medical Examiner - Allegany Co.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

CERTIFICATE OF DEATH

06639

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs
Hospital, Institution, or street address, where death occurred: Memorial Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 931 Jay St.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Edward Franklin Ogle
3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 28 1926

8. AGE:

Years	Months	Days	If less than one day
18	9	17	____ hrs. ____ min.

9. Birthplace Cumberland, Md. (Town, county, and state)
10. Usual occupation Student
11. Industry or business
FATHER 12. Name James Ogle
13. Birthplace Md.
MOTHER 14. Maiden name Grace Bittinger BURHMAN
15. Birthplace Ind.
16. Informant Mrs Grace Ogle
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 '45 (month) (day) (year)
Cemetery or crematory Evergreen Cem
Location Cumberland
18. Funeral director Louis Stein Sons
Address Cumberland
19. July 18, 1945 Walter R. Frantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945 at 9:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1945 to July 15 1945
and that I last saw h... alive on July 1st 1945

Immediate cause of death	DURATION
Uremia	2 weeks
Due to Acute Hydronephrosis	
Due to Appendicitis Ruptured	4 Mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____
Autopsy results ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ injured at work?

23. SIGNATURE W. S. Coover M.D.
M. D. or other
Address 133 Va Ave Date signed 7/16/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06640

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40. Years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 404. Goethe St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William O'Mara

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret O'Mara

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 11 1866

8. AGE: Years	Months	Days	If less than one day
79	2	20	..... hrs. ..... min.

9. Birthplace: Minnesota
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Fruit Nursery

FATHER
12. Name: Patrick O'Mara
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridget McKenna
15. Birthplace: Unknown

16. Informant: John O'Mara
Address: 1882 Penthley Ave, Akron, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/2/45 (month) (day) (year)

Cemetery or crematory: St. Patricks Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug. 1, 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1945 at 4:P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1945 to July 31 1945 and that I last saw h.m alive on July 31 1945

Immediate cause of death	DURATION
Uremia.	1 wk.
Cardio-renal vascular	10 yrs.
Due to: disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Confirmed above diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Lyle R. Eveleth M.D.
M. D. or other

Address: 36 Greene St Date signed 8/1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH ★

06641

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 8. Years

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryl and County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 444 Pine Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Gertrude Page

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Jesse Page

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): January 10, 1886

8. AGE:

Years	Months	Days	If less than one day
59	6	0	...hrs. ...min.

9. Birthplace: Hamilton, Louden Co, Virginia
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER
12. Name: Fenton Simms
13. Birthplace: Virginia

MOTHER
14. Maiden name: Annie Davis
15. Birthplace: Virginia

16. Informant: Jesse Page
Address: 444. Pine Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/13/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 13, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1945, at 1[illegible] A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 7 1945 to July 10 1945 and that I last saw h[illegible] alive on July 10 1945

Immediate cause of death: Sudden Pulmonal Thrombosis — DURATION: 40 minutes

Due to:

Due to:

Other conditions: Acute Appendicitis, 1 week
(Include pregnancy within 3 months of death)

Major findings of operations: Acute Appendicitis — Date of op. 7-10-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. J. Johnson M.D. M. D. or other

Address: Cumberland Md. Date signed 7-11-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06642

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17. Years

Hospital, institution, or street address where death occurred:
Constitution Swimming Pool

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 316. Independence St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Ronald Payne

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 14 1928

8. AGE: Years	Months	Days	If less than one day
17	2	17	...hrs. ...min.

9. Birthplace: Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation: School

11. Industry or business: "

FATHER
12. Name: Harry R. Payne
13. Birthplace: Ridgeley, W. Va.

MOTHER
14. Maiden name: Rosemary Twigg
15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Theodore Williams
Address: 316. Independence St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/4/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 3 1945 (Date rec'd by registrar) Winter R. Frantz Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: July 1st., 1945, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Accidental Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 7-1-45

Where did injury occur? Cumberland, (City or town) Allegany, (County) Md. (State)

Injured at home, farm, industry, public place (where?): Swimming Pool

Means of injury: drowning Injured at work? no

23. SIGNATURE: Prince H. Bosley M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 7-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06643

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred: 15 Maple

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: 15 Maple Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Barbara Knapp Lemin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Benj. Lemin

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Aug. 10 - 1882

8. AGE: Years: 62 | Months: 11 | Days: 0 | If less than one day: ... hrs. ... min.

9. Birthplace: Frostburg, Allegany Co. Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

MOTHER FATHER

12. Name: Christopher Knapp

13. Birthplace: Germany

MOTHER

14. Maiden name: Susanna Trade

15. Birthplace: Cresaptown, Md.

16. Informant: Mr. Benj Lemin

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13-1945 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg R.F.D. Md

18. Funeral director: M. Buchanan

Address: Lonaconing, Md.

19. 7-12-45 (Date rec'd by registrar) Mrs. Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10th 19 45 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 22 19 41 to July 10 19 45 and that I last saw h... alive on July 17 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	30 min
Due to: Hypertensive heart Disease	5 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Hilda Jarrell Key M.D. M. D. of other

Address: Frostburg Md Date signed 7/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

CERTIFICATE OF DEATH

06644

Reg. Dist. No. 6-1

1. PLACE OF DEATH:

County Allegany

City or town Rural - 3½ mi. West of Oldtown Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:
W.M.R.R. - 3½ mi. West of Oldtown

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Rural - 3½ mi. West of Oldtown,
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ernest William Rader

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 12, 1933

8. AGE: Years	Months	Days	If less than one day
11	6	20	hrs. min.

9. Birthplace Oldtown, Allegany County, Md.
(Town, county, and state)

10. Usual occupation School

11. Industry or business

FATHER 12. Name Albert Rader

FATHER 13. Birthplace Pendleton Co. W.Va.

MOTHER 14. Maiden name Goldie Robertson

MOTHER 15. Birthplace Maryland

16. Informant Albert Rader

Address Oldtown, Maryland

17. Burial Date thereof July 4 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenridge Cemetery

Location Near Oldtown

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. July 4 1945 Mrs. C. A. Shankle
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH July 2nd, 1945 at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 , to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Shock; Hemorrhage	killed instantly
Due to Body severed at diaphragm	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7-2-45

Where did injury occur? Near Oldtwon, Allegeny, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) W.M.R.R. track

Means of injury struck by engine Injured at work? no

23. SIGNATURE Prince H. Bruce, M.D.
M. D. or other

Address Cumberland, Maryland Date signed 7-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-D

06645

CERTIFICATE OF DEATH

★ Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred: Miners' Hospital
How long in hospital or institution? 6 mos. 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 69 Braddock Rd
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Katherine Price Sloan

3.(b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Alexander Sloan
6.(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): May 18, 1877
8. AGE: Years: 68 Months: 2 Days: 0 If less than one day: ____ hrs. ____ min.
9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
FATHER 12. Name: J. Alex. Price
13. Birthplace: Farm - Charles County, Md.
MOTHER 14. Maiden name: Anna Hanson Beall
15. Birthplace: Farm-Charles County, Md.
16. Informant: Mrs. Inglehart
Address: Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: M. E. Eichhorn
Address: Lonaconing, Md.
19. 7-19 1945 (Date rec'd by registrar) Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1945 at 3 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19__ to July 18 1945
and that I last saw her alive on July 18 1945
Immediate cause of death: Carcinoma of Lung — DURATION: 8 mo
Due to: —
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)
Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: W. M. Lee M.D.
M. D. or other
Address: Frostburg Md Date signed July 19 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

06646

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 735 Baltimore Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 735 Baltimore Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Cora Jane Sturtz

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Charles H. Sturtz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12, 1871

8. AGE: Years	Months	Days	If less than one day
74	3	26	..... hrs. ..... min.

9. Birthplace: Glencoe Pa
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: Henry Mantz

FATHER — 13. Birthplace: Pa

MOTHER — 14. Maiden name: Mary J Fair

MOTHER — 15. Birthplace: Pa

16. Informant: Mrs Nellie C Miller

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jul 12 1945 (month) (day) (year)

Cemetery or crematory: Beneficial Cem.

Location: Cumberland Md

18. Funeral director: Loats Funeral Home

Address: Cumberland Md

19. July 11 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1945 at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1945, to July 8 1945, and that I last saw her alive on July 8 1945

Immediate cause of death: Chronic Myocarditis — DURATION: 5 yrs.

Due to:

Due to:

Other conditions: General arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. E. Jones M. D. or other

Address: Cumberland, Md Date signed: 7-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

3-06647 Hyndman 4

★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 41 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Ellerslie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ray LeRoy Troutman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 25, 1945

8. AGE: Years	Months	Days	If less than one day
	1	19	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Carl E. Troutman
13. Birthplace Hyndman, Pa.

MOTHER
14. Maiden name Elsie M. Hosselrode
15. Birthplace Pennsylvania

16. Informant Mrs. Carl E. Troutman
Address Ellerslie Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18 1945 (month) (day) (year)
Cemetery or crematory Porter Cemetery
Location Hyndman Rural

18. Funeral director Harvey D. Zeigler
Address Hyndman, Pa.

19. July 18, 1945 (Date rec'd by registrar) Wintie R. Traub, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14 1945 at 5:05P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1945, to July 14 1945
and that I last saw him alive on July 14 1945

Immediate cause of death	DURATION
Stomach Indigestion	2 wks
Due to Pyloric Spasm	1 wk
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address [illegible] Date signed 7-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (d)

CERTIFICATE OF DEATH

06648

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred: 915 Maryland Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 915 Maryland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Hallam Basford Twigg

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sally M. Spitzer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 24 1865

8. AGE:

Years	Months	Days	If less than one day
80	1	7	..... hrs. ..... min.

9. Birthplace: Oldtown, Md.
(Town, county, and state)
10. Usual occupation: Car repairman (Ry.)
11. Industry or business: Retired 30 yrs.
FATHER 12. Name: Michael Twigg
13. Birthplace: Md.
MOTHER 14. Maiden name: — Alderton
15. Birthplace: Md.
16. Informant: Mitland V. Twigg
Address: Cumberland, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3 45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland Md
18. Funeral director: Louis Stein, Inc.
Address: Cumberland
19. Aug 1 19 45 (Date rec'd by registrar) Winter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 45, at 7 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 19 42 to July 31 19 45
and that I last saw h[illegible] alive on July 31 19 45

	DURATION
Immediate cause of death: Coronary Thrombosis	2 days
Due to: Arteriosclerosis	5 yrs.
Due to:	
Other conditions: Diabetes	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. E. Blowers M.D.
M. D. or other
Address: 133 Va Ave Date signed 7/31/45

WITHIN CORPORATE LIMITS

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

06649

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 Years

Hospital, institution, or street address where death occurred: 111 West Elder Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 111 West Elder Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth VanPelt

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John D. VanPelt

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): September 4 1881

8. AGE: Years	Months	Days	If less than one day
63	9	27	... hrs. ... min.

9. Birthplace: Lonacoming, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER
12. Name: Thomas Russell
13. Birthplace: Scotland

MOTHER
14. Maiden name: Margaret Milburn
15. Birthplace: England

16. Informant: Thomas Russell
Address: 440 Seymoure St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/3/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

16. Funeral director: William H. Kight
Address: Cumberland, Md.

19. July 3, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1945, at 7-30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940 to July 1 1945 and that I last saw her alive on June 29 1945

	DURATION
Immediate cause of death: Diabetes Mellitus	15 yrs
Due to: Arterio Sclerosis	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: H. H. Gleason M.D. M. D. or other

Address: 126 ... St. Cumberland Date signed: 7/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06650

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Miller Mine - Near Midland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5-2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Miller Mine - Near Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: James Henry Hagus

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Clara Robertson

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): December 4 1865

8. AGE:

Years	Months	Days	If less than one day
79	7	19	..... hrs. ..... min.

9. Birthplace: Bars Mountain Near Midland
(Town, county, and state)

10. Usual occupation: Coal Mining

11. Industry or business: Consolidation Coal Co.

FATHER
12. Name: Henry Hagus
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Henry Hagus
Address: Youngstown Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing Md

19. July 29 1945 (Date rec'd by registrar) D. E. Bowman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death: Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other

Address: Lonaconing Md Date signed July 29 '45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46a)

CERTIFICATE OF DEATH

06651

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 yrs.

Hospital, institution, or street address where death occurred: 805 Maryland Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 805 Maryland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Edgar Warren Wise

3.(b) Social Security Number: 217-10-7952

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Christina Fink

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 17 1877

8. AGE: Years	Months	Days	If less than one day
67	10	14	____ hrs. ____ min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: Silas Wise
13. Birthplace: Md.

MOTHER
14. Maiden name: Elizabeth Africa
15. Birthplace: Md.

16. Informant: Miss Elanor Wise
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 2 45 (month) (day) (year)

Cemetery or crematory: St. Johns Cath.

Location: Cumberland

18. Funeral director: Louis Stein & Son

Address: Cumberland.

19. Aug 1 (Date rec'd by registrar) 19 45 Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 45, at 2 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 19 45 to July 31 19 45 and that I last saw ____ alive on July 30 19 45

	DURATION
Immediate cause of death: Carcinoma of Esophagus	Hours
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Biopsy - Feeding Tube

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Oscar L. Turner M. D. or other

Address: Cumberland Date signed: July 31, 1945

WITHIN CORPORATE LIMITS

06652

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1223)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNSYLVANIA County SOMERSET
City or town SOMERSET
(If outside city or town limits, write RURAL and give nearest town)
Street No. 440 S. KIMBERLY ST.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Elias
MR. ELIAS ZEARFOSS

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife CORA ZEARFOSS
6.(c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) SEPT. 12, 1868

8. AGE: Years	Months	Days	If less than one day
76	10	5	....hrs. ....min.

9. Birthplace PENNSYLVANIA (Town, county, and state)
10. Usual occupation UNABLE TO WORK
11. Industry or business

FATHER
12. Name BENJAMIN ZEARFOSS
13. Birthplace PENNSYLVANIA

MOTHER
14. Maiden name CATHERINE SAYLOR
15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 19-45 (month) (day) (year)
Cemetery or crematory HUSH[illegible] CEMETERY
Location SOMERSET, PA.
18. Funeral director Blair R. Hoover
Address Somerset, Pa.

19. July 17 1945 Winter R. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 17 1945, 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1945, to July 17 1945 and that I last saw ... alive on July 17 1945

Immediate cause of death	DURATION
Bronchopneumonia	
Due to Pulmonary thrombosis	
Due to Ruptured duodenal ulcer	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Obstruction & gangrenous intestines Date of op. 7/15/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. E. Clutwell M. D.
M. D. or other
Address Cumberland Md. Date signed 7/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24a)

CERTIFICATE OF DEATH

06653

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
305 Va. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 305 Va. Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Ziler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Mildred Forbek Ziler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 13, 1898

8. AGE:

Years	Months	Days	If less than one day
47	1	1	...hrs. ...min.

9. Birthplace: Doe Gully, W. Va.
(Town, county, and state)

10. Usual occupation: Car Inspector

11. Industry or business: B. & O. R.R. Co.

FATHER
12. Name: Peter Ziler
13. Birthplace: Doe Gully W. Va.

MOTHER
14. Maiden name: Bertie Youngblood
15. Birthplace: Great Capon, W. Va.

16. Informant: Mildred Ziler
Address: 305 Va. Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 18, 1945 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. July 17 1945 (Date rec'd by registrar) Winston L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14th., 1945 at about 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Prince H. Bolton M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 7-14-45